Clean Care is Safer Care

Background to Clean Care is Safer Care

In previous years, WHO Global Patient Safety Challenges were born from calls from around the world on specific patient safety issues, and were also reflected in global campaigns, which have brought together expertise and evidence to raise awareness, and to catalyze political and professional commitment on these important topics. They have also generated knowledge, recommendations and actions to improve the safety of patients receiving care globally.

The focus and objectives of Clean Care is Safer Care

The first of these Challenges, Clean Care is Safer Care, which was launched in 2005, targeted the important aspect of reducing health care-associated infections (HCAIs). HCAI is the most frequent harmful event in health-care delivery and occurs...
In 10 years, Clean Care is Safer Care has evolved to become the Infection Control Programme hosted by the new WHO HQ Service Delivery and Safety department.

Continuing to aim to reduce healthcare-associated infection worldwide.
# 1st GPSC Change Model

**3 main objectives**

<table>
<thead>
<tr>
<th>Burden of HCAI</th>
<th>1. Awareness raising</th>
</tr>
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<tbody>
<tr>
<td>Stakeholders' engagement</td>
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<tr>
<td>Country pledges</td>
<td>2. Mobilising nations</td>
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<td>National campaigns</td>
<td></td>
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<tr>
<td>Implementation strategies</td>
<td>3. Technical guidelines and tools</td>
</tr>
</tbody>
</table>
Awareness raising on HAI endemic burden

Allegranzi B et al. 
Lancet 2011;377:228-41

Bagheri Nejad S, et al. 
Bull OMS 2011;89:757-765

Published on 5 May 2011
http://www.who.int/gpsc/en/
Political commitment is essential to achieve improvement in infection control

• Ministerial pledges to the 1st Global Patient Safety Challenge

I resolve to work to reduce health care-associated infection (HCAI) through actions such as:

■ acknowledging the importance of HCAI;
■ hand hygiene campaigns at national or sub-national levels;
■ sharing experiences and available surveillance data, if appropriate;
■ using WHO strategies and guidelines…
137 countries committed to address health care-associated infection

World population coverage: > 93%

Sierra Leone, 137th country
On 5 May 2015, His Excellency the Sierra Leone Minister of Health and Sanitation pledges to fight against healthcare-associated infections in memory of the fallen heroes of Sierra Leone Health Sector due to Ebola Viral Disease.
Adoption and adaptation of Clean Care is Safer Care worldwide
From country pledges

• ... to patient point of care
Implementation levels

Global level

First Global Patient Safety Challenge

Facility-level: point of care
Implementation strategy and toolkit for the WHO Guidelines on Hand Hygiene in Health Care

Knowledge & evidence → Action

World Health Organization
Patient Safety
SAVE LIVES
Clean Your Hands
What is the WHO Multimodal Hand Hygiene Improvement Strategy?

Based on the evidence and recommendations from the WHO Guidelines on Hand Hygiene in Health Care (2009), made up of 5 core components, to improve hand hygiene in health-care settings:

ONE  System change
Alcohol-based handrubs at point of care and access to safe continuous water supply, soap and towels

TWO  Training and education
Providing regular training to all health-care workers

THREE  Evaluation and feedback
Monitoring hand hygiene practices, infrastructure, perceptions, & knowledge, while providing results feedback to health-care workers

FOUR  Reminders in the workplace
Prompting and reminding health-care workers

FIVE  Institutional safety climate
Individual active participation, institutional support, patient participation

Allegranzi B. et al. The Lancet Infectious Diseases 2013, in press
A successful branding
My 5 Moments for Hand Hygiene
Focus on caring for a patient with a Urinary Catheter

1. Before Touching a Patient
2. Before Performing a Procedure on a Patient
3. After Touching the Patient
4. After Performing a Procedure on a Patient
5. After Removing Urinary Catheter

Clean Your Hands When Handling a Urinary Catheter and Drainage System

- Immediately before and after touching the urinary catheter and drainage system with sterile gloves or before touching the equipment, such as the drainage bag or any part of the drainage system.
- When the catheter is removed, immediately wash your hands with soap and water or use an antimicrobial hand rub.
- When caring for a patient with an indwelling urinary catheter, wash your hands before and after touching the catheter site, as well as before and after touching the drainage bag or any part of the drainage system.
- Immediately after performing any task involving the urinary catheter, drainage system, or equipment, as well as when caring for a patient with an indwelling urinary catheter, wash your hands with soap and water or use an antimicrobial hand rub.

5 Key Additional Considerations for a Patient with a Urinary Catheter

- Make sure that there is an appropriate indication for the indwelling urinary catheter.
- Use a closed urinary drainage system, and keep it closed.
- Insert the catheter aseptically using sterile gloves.
- Assess the patient at least daily to determine whether the catheter is still necessary.
- Patients with indwelling urinary catheters do not need antibiotics (including for asymptomatic bacteriuria), unless they have a documented infection.

World Health Organization
SAVE LIVES
Clean Your Hands
No Action Today
No Cure Tomorrow
My 5 Moments for Hand Hygiene

Focus on caring for a patient with a central venous catheter

1. BEFORE Touching a Patient
2. BEFORE Cleaning/Accessing the Catheter
3. AFTER Cleaning/Accessing the Catheter
4. AFTER Touching Patient
5. AFTER Leaving the Area

Key additional considerations for central intravenous catheters:

1. Indication: Ensure that a central intravenous catheter is indicated. Remove the catheter when no longer necessary/life-saving.
2. Insertion/Site Maintenance
   a. Airlock/leakage
   b. Insertion site leakage
   c. Indication
3. Avoid inserting catheters into the femoral vein.
4. Prepare clean skin with an antiseptic solution.
5. Use sterile site preparation during insertion.
   a. Surgical mask, sterile gloves, sterile gown, sterile drape.
6. Perform aseptic technique every 2 days and transparent dressings every 7 days; update dressings whenever visibly dirty.

Immediately after any task that could involve body fluid exposure, such as:

- Inserting or removing the catheter
- Drawing blood from the catheter

My 5 Moments for Hand Hygiene

Focus on caring for a patient with a peripheral venous catheter

1. BEFORE Touching a Patient
2. BEFORE Accessing the Catheter
3. AFTER Accessing the Catheter
4. AFTER Touching Patient
5. AFTER Leaving the Area

Key additional considerations for peripheral intravenous catheters:

1. Indication: Ensure that a peripheral venous catheter is indicated. Remove the catheter when no longer necessary/life-saving.
2. Insertion/Site Maintenance
   a. Airlock/leakage
   b. Indication
3. Avoid inserting catheters into the femoral vein.
4. Prepare clean skin with an antiseptic solution.
   a. Indication
   b. Site leakage
   c. Indication
5. Use sterile site preparation during insertion.
   a. Surgical mask, sterile gloves, sterile gown, sterile drape.
6. Perform aseptic technique every 2 days and transparent dressings every 7 days; update dressings whenever visibly dirty.

Immediately after any task that could involve body fluid exposure, such as:

- Inserting or removing the catheter
- Drawing blood
My 5 Moments for Hand Hygiene

Focus on caring for a patient with an endotracheal tube

1. Before Touching a Patient
2. Before Giving the Patient Food or Drink
3. After Touching Patient’s Fluid Exposures
4. After Touching a Patient
5. After Touching Patient’s Surroundings

Key additional considerations for adult patients with endotracheal tubes:

- Avoid intubation and use non-invasive ventilation whenever appropriate.
- If possible, provide endotracheal tubes with subglottic secretion drainage ports for patients likely to require more than 48 hours of intubation.
- Elevate the head of the bed to 30–45°.
- Manage ventilated patients without sedatives whenever possible.
- Assess readiness for extubation every day by performing spontaneous breathing trials with sedatives turned off (in patients without conditions).
- Perform regular oral care aseptically using clean, non-sterile gloves.
- Facilitate early exercise and mobilization to maintain and improve physical condition.
- Change the ventilator circuit only if visibly soiled or malfunctions.

World Health Organization
Clean Your Hands
Save Lives
Clean Care is Safer Care
2005-2015

World Health Organization
LARGEST INCREASE IN AFRICAN REGION

Equates to over 10 million staff dedicated to protecting over 4 million patients
WHO Service Delivery & Safety dept – Clean Care is Safer Care
Focus in 2014-2015 (1)

▪ Support for and consolidation of hand hygiene improvement through SAVE LIVES: Clean Your Hands campaign, CleanHandsNet, and POPS – 5 May 2015

▪ Infection prevention and control (IPC) for the Ebola outbreak
  ▪ Response
  ▪ Recovery
  ▪ Resilience

▪ Country support for capacity building and strengthening the core components of IPC programmes

▪ Burden of HAI worldwide – SSI burden update
WHO Service Delivery & Safety dep – Clean Care is Safer Care
Focus in 2014-2015 (2)

- Prevention of surgical site infection
  ✓ New Guidelines under development
  ✓ Surgical Unit-based Safety Programme (SUSP) project in African hospitals
    ➢ Manual on sterilization and safe processing of medical devices (launch in June 2015)

- Injection safety new global initiative
  ✓ New Policy launched in February 2015
  ➢ New Global Injection Safety campaign (to be launched)

- AMR prevention and control in health care
  ✓ AMR IPC expertise provided in consultations
  ✓ AMR hand hygiene resources produced for 5 May 2014
5 May 2015: *hand hygiene is the entrance door to strengthening health-care systems and delivery*
Impact of hand hygiene to reduce transmission and infections by MDROs in health-care settings a systematic literature review

http://www.who.int/gpsc/5may/EN_PSP_GPSC1_5May_2014/en/
Summary results

• From Jan. 1980 to Dec. 2013
• **39 studies** on hand hygiene as the key intervention implemented in the study period and including data about impact on MDROs' infection and/or transmission rates, as well as on hand hygiene indicators, were identified

• **Only 4/39** studies failed to demonstrate an impact of hand hygiene interventions or improvement in the MDRO’s infection and/or colonization
  One of these studies *did not show any significant improvement of hand hygiene compliance* thus explaining the failure to reduce infections, while another study was a *low/quality retrospective study*

• **Additional 60 studies** investigated the impact of hand hygiene (HH) to reduce MDRO’s infections as part of interventions including other infection control measures
Awareness raising - a social marketing strategy #safeHANDS and country engagement
Are you ready for 5 May 2015?
Are you ready for 5 May 2015?

I provide clean care

#safeHANDS

FLAMINIA, ITALY
Je mérite des soins propres

#safeHANDS

MALOU 94 ans
Families pledging for #safeHANDS for their parents
1st Hand Sanitizing Relay Guinness World Record on Compliance with Hand Hygiene
Hong Kong Baptist Hospital

Get ready & Participate from 5 May to 5 Sept 2015
Hong Kong, 5 May 2014
START POINT
Key lessons learned for infection prevention and control (IPC) from the Ebola outbreak

• Absence of IPC basic measures and infrastructures both in the community and in healthcare settings led to the unprecedented situation of this outbreak

• The lack of access to safe water, of proper hygiene, and poor sanitation contributed to the propagation of the virus both the community and healthcare facilities
Ebola Recovery Assessment
Water, sanitation, and hygiene

- Lack of access to water, sanitation, and poor hygiene practices were problems pre-Ebola, exacerbated the outbreak, and will remain problems post-Ebola

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Guinea</th>
<th>Liberia</th>
<th>Sierra Leone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water supply coverage</td>
<td>92% (urban areas; very poor reliability)</td>
<td>65% (rural areas; 50% fully functioning year-round)</td>
<td>60%</td>
</tr>
<tr>
<td>Access to improved sanitation</td>
<td>18.9%</td>
<td>16.8%</td>
<td>13%</td>
</tr>
</tbody>
</table>
Global report-availability of soap and water or handrubs is sub-optimal

- Review based on data from 54 countries, representing over 66,000 health care facilities
- Globally, 35% of facilities have no soap and water or handrubs for hand hygiene
- No data on functionality or frequency of use
- Other indicators similarly low: 38% of facilities have no water, 19% have no sanitation and 42% lack a system for safe disposal of health care waste

Beyond handwashing-preventing infection requires a comprehensive approach

- Water Quality *(safe management; no fecal contamination)*
- Water Quantity *(5-300 liters/person/day depending on type of facility and services provided)*
- Excreta disposal and management
- Greywater disposal and management
- Health care waste management
- Food storage and preparation
- Control of vectorborne disease
- Hygiene promotion

Global Action Plan to address water, sanitation and hygiene (WASH) in health care facilities

- WHO and UNICEF hosted global meetings in 2014 (Madrid) and 2015 (Geneva) to develop basis for plan
- WASH important input for, not separate from, infection prevention and control and the Clean Care is Safer Care efforts
- Main elements of draft plan include:
  - National policies, standards and targets
  - Financing and human resources-improving WASH services
  - Monitoring
  - Advocacy (global, national and local)
- Early adopters to address issue comprehensively include Ethiopia, Sierra Leone and Zambia
Guideline development process

- Development of key research questions
- Systematic literature reviews
- Evidence-to-recommendations approach using the GRADE framework
- Expert consultation
- WHO Guideline Review Committee

Issued in December 2014


1. Are chlorine solutions effective for hand hygiene in health care?
2. Are chlorine solutions effective for disinfection of gloves?
3. Does the use of chlorine solutions for hand hygiene cause health workers’ skin irritation or lesions, respiratory side effects or any other adverse reactions?
4. Does glove disinfection with chlorine solutions cause damage to glove permeability or increased perforations?
Local production of alcohol-based WHO formulation, Monrovia, Liberia, November 2014  (Courtesy Dr Olivier Hagon)

Support: CleanHandsSaveLives.org and Swiss National Aid
JOIN US!

Info&Tools – 5 May – SAVE LIVES: Clean Your Hands
http://www.who.int/gpsc/5may/en/

POST YOUR PHOTOS/SELFIES at:
http://cleanhandssavelives.org
Follow, like and spread
@didierpittet
@GLOBAL_POPS
@WHO
who.int/5may/en/
CleanHandsSaveLives.org

#safeHANDS
WAR TO WASH – THE CASE FOR HAND HYGIENE IN POST CONFLICT SETTINGS (AFGHANISTAN)
OVERVIEW

- Afghanistan – Context and healthcare delivery system
- Monitoring and Evaluation project - Johns Hopkins
- Hand Hygiene – Opportunities and Challenges
AFGHANISTAN: SECURITY MAP (2011)
INSECURITY – A MAJOR CHALLENGE

Troops deployed
119,500 Nato*
Approx
26,500 Enduring Freedom
*June 2010 latest figures

Source: UN/Isaf/US Government
AFGHANISTAN – COUNTRY CONTEXT

- **Capital**: Kabul
- **Area**: 251,825 sq mi; slightly smaller than Texas, highly mountainous terrain
- **Population**: 31,056,997 (July 2006 estimate)
  - 80% Sunni Muslim, 19% Shia Muslim
- **Main ethnic groups**: Pashtun, Tajik, Hazara, Uzbek
- **Labor force**: Over 80% in agriculture (farming, sheep, goats)
- **Covered by**: estimated 5-7 million landmines
- **Leading illicit opium producer** in 2005 supplying 89% of the opium produced in the world. 1/3 of the GDP comes from opium trade
**AFGHANISTAN – COUNTRY CONTEXT (CONT'D.**)  

<table>
<thead>
<tr>
<th>Demographic &amp; Health Indicators</th>
<th>Values</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands) 2011, total</td>
<td>32358</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Population (thousands) 2011, under 18</td>
<td>17219</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Population (thousands) 2011, under 5</td>
<td>5686</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Population annual growth rate (%), 1990-2011</td>
<td>4</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Population annual growth rate (%), 2011-2030</td>
<td>3</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Crude death rate, 2011</td>
<td>16</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Crude birth rate, 2011</td>
<td>43</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Life expectancy, 2011</td>
<td>49</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Total fertility rate, 2011</td>
<td>6</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Urbanized population (%), 2011</td>
<td>24</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>77</td>
<td>AMS 2010</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>327</td>
<td>AMS 2010</td>
</tr>
<tr>
<td>DPT 3 coverage (%)</td>
<td>35</td>
<td>MICS 2010/11</td>
</tr>
<tr>
<td>Fully immunized (12-23 months) (%)</td>
<td>18</td>
<td>MICS 2010/11</td>
</tr>
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</table>

**Compare with**

- IMR (2001) 165 per 1,000 *
- MMR (2002) 1600 per 100,000 live births **
- MMR (2002) of a district in Badakshan = 6400 per 100,000 live births **

* UNICEF ** CDC / UNICEF
Primary Health Care – The Backbone of any country’s health system
BPHS AND EPHS

- Basic Package of Health Services (BPHS) – Primary Care (Basic Health Centers, Sub centers, Comprehensive Health Centers)
- Essential Package of Health Services (EPHS)
  - Hospital based services
JHU’S MONITORING AND EVALUATION

- Independent third party (contracted out)
- **Health Services Delivery**
  - Balanced Score Card Approach
  - 2004 - 2013
  - Monitor delivery of basic health care services in 34 provinces
- **Population level**
  - Household surveys
AFGHANISTAN – HOSPITAL ASSESSMENT, 2012-2013

- The Balanced Scorecard Report for Afghanistan hospitals
- Sample size: 97
- Types of hospitals:
  - Kabul hospitals (KHs)
  - District Hospitals (DHs)
  - Provincial hospitals (PHs) and
  - Regional hospitals (RHs)
DOMAINS OF ASSESSMENT

- Domain A: Client and Communities
- Domain B: Human resources
- **Domain C: Physical Capacity**
- **Domain D: Quality of Service Provision**
- Domain E: Management Systems
- Domain F: Functionality Indicators
- Domain G: Ethics and Values
DOMAIN C – PHYSICAL CAPACITY

- 4 sub-domains:
  - C1 - Communications and Functional transportation
  - C2 - Infrastructure
    - Infrastructure index
  - C3 - Supplies, Drugs, and Equipment
  - C4 - Service Availability
DOMAIN C – PHYSICAL CAPACITY

C1: Communications and Transport
This sub-domain consists of one index which assesses the functional transportation, and communications facilities.

C2: Infrastructure
This sub-domain consists of one index which assess the adequacy of the physical structure and utilities of the hospital.

C3: Supplies: Drugs and Equipment
This sub-domain includes two indices which assess the presence, adequacy, and functionality of available drugs and equipment.

C4: Service Availability
This sub-domain includes six indices which assess the provision of services.

Source:
Essential Package of Health Services Balanced Score Card Report 2012-2013, MoPH Afghanistan
DOMAIND D – QUALITY OF SERVICE PROVISION

- 2 sub-domains:
  - Enabling Environment (Systems present to deliver quality services)
  - Quality of Care (direct observation of provider-patient interaction to assess quality of care delivered)
    - Client history and Physical exam
    - Client counseling
    - Universal precautions
Photo credits: MSH (Afghanistan, WASH Campaign)
SUMMARY – HAND HYGIENE

- Slow Progress Areas
  - Surgical Areas of hospitals
  - Running water, taps, basins in hospitals
  - Awareness on the rise

- Challenges (opportunities for improvement)
  - Little or no systematic measurement yet
  - Promotion dependent on funding/NGO priorities
  - Limited resources and a lot to do!
HEALTH SYSTEM CHALLENGES

- Health System Level
  - Infrastructure Limited
  - Fragmentation
  - Donor funding
  - Equity
  - Workforce Shortages (insufficient female health workers, cultural restrictions on women)
- Literacy
- Security
Thank you !
“Being a nurse isn’t about grades. It’s about being who we are. No book can teach you how to cry with your patient. No class can teach you how to tell their family that their parents have died or are dying. No professor can teach you how to find dignity in giving someone a bed bath.

A nurse is not about the pills or the charting. It’s about being able to love people when they are at their weakest moments.”
Multiple traumas, a unit full of ventilators, and patients trying to die on me all day... I'm sorry what were you saying about your busy day with the stapler?

**NURSING REQUIREMENTS**

(to): have a memory of an elephant, an angels patience, a heart the size of the sun, eyes on the back of your head, a nasal filter, eight arms like an octopus, resistant legs, a back to hold and transfer full grown adults, a five liter bladder, and an impenetrable immune system.

**BEING A NURSE IS**

90% CALLING, 10% JOB
Every day, you will experience people at their very best and at their very worst

WASH YOUR HANDS
WHEN YOU TREAT A PATIENT,
YOU'RE TREATING THEIR FAMILY TOO
You'll go through 4 pairs of shoes a year

FAITH IS MEDICINE
AS IS LAUGHTER
AS IS MUSIC • AS ARE DOGS
YOU'VE GOT TO BE ONE PART SURGICAL STEEL
and nine parts love

DON'T BE JUST
ANOTHER NURSE
DRINK LOTS OF WATER
AND WASH YOUR HANDS

YOU TREAT ONE
PATIENT AT A TIME
And then you move on

DON'T FORGET TO
NURSE YOURSELF
You can't fake compassion

PATIENTS NEED HOPE
FAMILIES NEED HONESTY

WASH YOUR HANDS
DOCTORS CAN'T DO WHAT THEY DO WITHOUT YOU

KIDS ARE GOING TO MAKE YOU CRY
REMEMBER TO SMILE
• 60 times/hour
• Average compliance ≈ 40%
Factors reducing HHC: State of the art

- Institutional
  - Unit type
  - Job type
  - Understaffing
  - Lack of commitment to ‘safety climate’

- Behavioural/Situational
  - Wearing gloves/protective gear
  - Inconvenient location of dispensers
  - Patient needs
  - ‘Forgetfulness’
  - High work-load/‘too busy’

- Bodily:
  - Dry/sticky hands

- Psychological (positive influence)
  - Perceiving oneself as role model
  - Peer pressure
  - Self-efficacy (to do HHC)
  - Perceived risk of infection
  - Perceived benefits of HHC against infection
  - Early learning about HWWS at home
What doesn’t work
OH, NO!
NOT ANOTHER POSTER ABOUT HAND WASHING!
Also don’t work
What works -- briefly

What’s on YOUR Hands?

- Money
- Cell Phone
- MP3 Player
- Remote Control
- Door Knob
- Faucer
- Pencils
- Basketball
- Computer Mouse
- Bathroom Door
- Keyboard
- School Books
- Desktop
- Bus Seat

Virtues and bacteria can live for several hours on many surfaces. What did you touch today?

Wash Those Germs Away!
Behaviour Change Problem

- **Institutional factors** can be associated with high long-term HHC, but are typically not manipulable.
- **Situational factors** are typically associated with low HHC, but not manipulable at scale or across situations.
- **Psychological factors** can be manipulated, but typically produce only temporary increases in HHC.
- Hence:

  Need to identify new, relevant, manipulable factors that will produce **sustained** increases in HHC.
BCD Behaviour Determination Model

- Social
- Motivated
- Reactive Brain
- Executive
- Body
- Physical Environment
- Social Setting
- Biological

Body

Behaviour
BCD HHC Analysis

traits, physiology, senses
planning, identity: ‘Professional nurse’; knowledge: ‘I’m protected’
motives: status, affiliation, nurture, disgust; rewards
reflexes, habits: HHC cued; skills
stages, props: dispenser placement; roles, scripts, routines; norms: modify expectations

Red: not relevant, not changeable or not sustainable
White: possible factor
BCD Resources

• Home page (with introduction, guide, example campaigns):
  • http://ehg.lshtm.ac.uk/behavior-centred-design/
WHO tools to help you improve hand hygiene in healthcare
http://www.who.int/gpsc/5may/tools/en/
Make hygiene happen: assess your readiness

People rarely move from current to ideal practices

Achieving excellent hand hygiene in healthcare is a continuum

Assess your readiness with the WHO Hand Hygiene Self-Assessment Framework 2010:

• Systems and hand hygiene infrastructure
• Training and education
• Evaluation and feedback
• Reminders in the workplace
• Institutional safety climate for hand hygiene

English/French/Spanish: http://www.who.int/gpsc/5may/hhsa_framework/en/
Make hand hygiene happen: small doable actions

For your healthcare facility:

1. Identify good hand hygiene practices that can be reinforced

2. Identify hand hygiene practices that are missing or can be improved

3. Identify incremental steps that:
   • move health workers from current practice to ideal practice
   • Have significant positive impact on health
   • Are feasible

4. Facilitate movement from step to step to achieve better hand hygiene, eg:
   • Sustainable hand hygiene facilities available, affordable, convenient
   • Education, promotion, role models, and motivation to instill a hand hygiene culture in your healthcare facility
Hygiene in the Post-2015 Agenda

• The United Nations is in the process of developing global goals and targets for post-2015

• The UNICEF/WHO Joint Monitoring Programme (JMP), a multi-stakeholder group, has recommended WASH targets and indicators

• Hygiene includes handwashing with soap and menstrual hygiene management

• Urge UN member states, donors, NGOs, and others to advocate for the inclusion of water, sanitation, and hygiene in post-2015 agenda
The Target

By 2030:

• to eliminate open defecation;

• to achieve universal access to basic drinking water, sanitation and **hygiene for households, schools and health facilities**;

• to halve the proportion of the population without access at home to safely managed drinking water and sanitation services; and

• to progressively eliminate inequalities in access.